

# Michigan Department of Health & Human Services Certificate of Need

Lewis Cass Building  
320 S. Walnut St.  
Lansing, Michigan 48933  
Phone: (517) 241-3344 - Fax (517) 241-2962

**AUTHORITY:** PA 368 of 1978, as amended  
**COMPLETION:** Is voluntary, but is required to obtain a Certificate of Need. If not completed, a Certificate of Need will not be issued.

The Department of Health & Human Services is an equal opportunity employer, services and programs provider.

## NONSUBSTANTIVE LETTER OF INTENT (LOI) ROUTING RECORD

**Facility Name:** \_\_\_\_\_

**CON Number:** \_\_\_\_\_

☐ Based on information supplied by the applicant on the Letter of Intent, forms have been assigned through the online system (CON E-Serve). Please use this form as an index by selecting the assigned documents/forms and submit with the CON application.

## APPLICATION COMPONENTS REQUIRED

Applicant must download the selected forms that are not available through the online system from [www.michigan.gov/con](http://www.michigan.gov/con), see "Electronic Forms" link. If you are unable to download any form, call (517) 241-3348 or 3344.

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: THIS FORM MUST BE RETURNED AS :  
: PART OF YOUR APPLICATION. :  
.....

**APPLICATION COMPONENTS REQUIRED WITH ALL APPLICATIONS**  
**(\* Must be completed by the applicant)**

Form No.	Form Required	Form Description		Application Page No. *
	<input checked="" type="checkbox"/>	CON Commission Work Plan		
CON-200-A	<input checked="" type="checkbox"/>	Instructions for Addressing & Completing CON Review Standards		
CON-100-Instructions	<input checked="" type="checkbox"/>	General Information and Instructions for Application for CON		
CON-100	<input checked="" type="checkbox"/>	Application for CON – All Applicants		
CON-110-F	<input checked="" type="checkbox"/>	Financial Components for Nonsubstantive Review		
CON-110-A	<input type="checkbox"/>	Health Facility Acquisition		
CON-110-B	<input type="checkbox"/>	Bed Replacement/Relocation Report		
CON-110-C	<input type="checkbox"/>	Mobile Host Site		
CON-110-D	<input type="checkbox"/>	Acquisition, Replacement or Relocation of a Covered Clinical Service		
CON-110-i	<input type="checkbox"/>	Change in Mobile Host Site (Nonsub Notice)		
<b>DOCUMENT REQUEST INDEX</b>	<b>Required</b> <input type="checkbox"/>	<b>Item A.</b>	Copy of current valid license.	
	<input type="checkbox"/>	<b>B.</b>	« FILED » Certificate of Assumed Name, if any, applicable to this project.	
	<input type="checkbox"/>	<b>C.</b>	« FILED » document that authorizes business entity to conduct business in the State of Michigan.	
	<input type="checkbox"/>	<b>D.</b>	« FILED » copy of Articles of Incorporation, Limited Liability Company, Proof of Partnership, or Proof of Sole Proprietorship.	
	<input type="checkbox"/>	<b>E.</b>	Existing and proposed site plans, as applicable.	
	<input type="checkbox"/>	<b>F.</b>	Existing and proposed floor plans (simple line drawings), as applicable.	
	<input type="checkbox"/>	<b>G.</b>	Copy of Applicant's proposed purchase/lease agreement(s), as applicable.	

**APPLICATION COMPONENTS REQUIRED WITH ALL APPLICATIONS**  
**(\* Must be completed by the applicant)**

<b>DOCUMENT REQUEST INDEX</b>	<b>Required</b> <input type="checkbox"/>	<b>Item</b> H.	Copy of vendor quotation(s) for the <u>Applicant</u> signed by vendor—no more than six months old.	
	<input type="checkbox"/>	I.	Copy of Applicant's current Radiation Safety Registration Certificate.	
	<input type="checkbox"/>	J.	Verification of Medicaid Participation, excluding applications for Nursing Home and HLTCU Beds. Central Service Coordinators for mobile networks must provide proof of Medicaid participation for at least two (2) host sites at the time the application is submitted to the Department and for all host sites prior to a decision. A new provider not currently enrolled in Medicaid shall submit a signed affidavit certifying that proof of Medicaid participation will be provided to the Department within six (6) months from the offering of services if a CON is approved.	
	<input type="checkbox"/>	L.	Copy of Service Agreement(s) between Central Service Coordinator and Host Site for mobile networks.	
	<input type="checkbox"/>	M.	Copy of current and proposed Route Schedules for the mobile network.	
	<input type="checkbox"/>	N.	Copy of Legal Description for parcel of land for the proposed site, when a postal address is not assigned to the site.	
	<input type="checkbox"/>	O.	Copy of Audited Financial Statements for existing providers including balance sheet, income statement, statement of cash flow, and footnotes to the financial statements. If not available, provide Reviewed Financial Statements.	
	<input type="checkbox"/>	P.	For new providers, if Audited Financial Statements are not available, provide unaudited current financial statements including a balance sheet, income statement, statement of cash flow and any notes. New entities must provide a current balance sheet, a projected income/cash flow statement for the first year of operation, and any notes to the financial statements.	
	<input type="checkbox"/>	Q.	For change of ownership projects, provide a letter from the current licensee or CON holder of the licensed health facility or CON-covered service, stating the intent to transfer ownership to the applicant.	

## COVERED CLINICAL SERVICES/HEALTH FACILITY

Form No.	Form Required	Form Description	Application Page No. *
CON-202	<input type="checkbox"/>	Review Standards for Urinary Extracorporeal Shock Wave Lithotripsy (UESWL) Services	
CON-204	<input type="checkbox"/>	Review Standards for Neonatal Intensive Care Services/Beds	
CON-205	<input type="checkbox"/>	Review Standards for Psychiatric Beds and Services	
CON-206	<input type="checkbox"/>	Review Standards for Surgical Services	
CON-208	<input type="checkbox"/>	Review Standards for Open Heart Surgery Services	
CON-209	<input type="checkbox"/>	Review Standards for Heart, Lung, and Liver Transplantation Services	
CON-210	<input type="checkbox"/>	Review Standards for Cardiac Catheterization Services	
CON-211	<input type="checkbox"/>	Review Standards for Megavoltage Radiation Therapy (MRT) Services	
CON-212	<input type="checkbox"/>	Review Standards for Computed Tomography (CT) Scanner Services	
CON-213	<input type="checkbox"/>	Review Standards for Magnetic Resonance Imaging (MRI) Services	
CON-214	<input type="checkbox"/>	Review Standards for Hospital Beds	
CON-217	<input type="checkbox"/>	Review Standards for Nursing Home and Hospital Long-Term-Care Unit (HLTCU) Beds	
CON-217-A	<input type="checkbox"/>	Nursing Home Certification Report	
CON-226	<input type="checkbox"/>	Review Standards for Pancreas Transplantation Services	
CON-227	<input type="checkbox"/>	Review Standards for Positron Emission Tomography (PET) Scanner Services	
CON-228	<input type="checkbox"/>	Review Standards for Air Ambulance Services	
CON-229	<input type="checkbox"/>	Review Standards for Bone Marrow Transplantation (BMT) Services	
CON-704	<input type="checkbox"/>	Surgical Utilization Report	
CON-706	<input type="checkbox"/>	CT Scanner Utilization Report	
CON-707	<input type="checkbox"/>	MRT Utilization Report	
CON-716	<input type="checkbox"/>	Cardiac Catheterization Utilization Worksheet	
CON-113	<input type="checkbox"/>	Short-term Nursing Care Program (Swing Beds)	